Contract Initiation Form



Please complete and email this form, any supplemental information and a copy of your W-9 to:

 $PHW_LTSSContracting@PaHealthWellness.com$

Legal Provider Name: (Name as it appears on the W-9)			
Tax ID #:			
NPI#:			
Primary Street Address:			
City, State, ZIP:			
County:			
Medicare #:			
Medicaid #:			
Legal Notices Address:			
Legal Notices Email:			
ATTN: (Individual Name and/or Title to whom Notice will be addressed)			
Contract Signer Name and Title:			
Please Check all that Apply			
	Medicaid (Health Choices and Community Health Choices)		
Contract Request for:	Medicare (AllWell) Exchange (Ambetter)		II)
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